Third Party Payer Day

Medicaid Services Administration
Michigan Medicaid
Provider Relations Section
Stephen Kuncaitis

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Provider Resources & Updates

www.michigan.gov/medicaidproviders

Provider Inquiry – (800) 292-2550

ProviderSupport@michigan.gov

Provider Tips

- CMS 1500 Claim Completion Instructions
- Professional Providers CHAMPS and General Updates
- CMS 1500 and UB04 Paper Claim Format
- ListServ Instructions
- MDCH Payment Liability
- Documentation Requirements

Medicaid Beneficiary Eligibility Verification System (EVS)

- **How to Check Eligibility Free**
  - **AVRS, 1-888-696-3510**
  - **WebDenis, 1-877-BLUE-WEB,**
  - **www.bcbsm.com**
  - **mihealth Card does NOT guarantee eligibility**
- **Other companies offer Medicaid eligibility for a service fee**

Crossover Claims

- Provider submits one claim to Medicare
  - Include your NPI and Beneficiary ID
- Medicare submits claim to Medicaid
  - Medicare will report appropriate CAS codes
- Medicaid will adjudicate your claim based on your NPI
- Claims will appear on your Remittance Advice within 7-14 days from Medicare EOB
- Make sure your NPI is reported correctly
- If claim does not appear within 30 days the claim must be resubmitted.

Replacement Claims

- Claim must be submitted as it should have appeared originally including any paid services.
- Replace Entire PAID Claims
  - Line Level Adjustments are not allowed
  - Rejected Claims are resubmitted as NEW claims
- Resubmission Code “7” with original Claim Reference Number
- NPI and Beneficiary ID MUST be the same as original Claim Reference Number
- Add brief explanation in comments

Void/Cancel Claims

- **PAID Claims**
- **Resubmit claim and only report one service line with $0.00**
- **Resubmission Code “8” with original Claim Reference Number**
- **NPI and Beneficiary ID MUST be the same as original Claim Reference Number**
- **Add brief explanation in comments**

Replacement/Void Claim Tips

- **Do not submit replacement or void/cancel claim when the entire claim rejected. If the claim is rejected, re-submit the *entire* claim.**

- **Be sure when claim replacing or voiding to use the *MOST RECENT APPROVED CRN!* Claim remarks are always required to explain why the claim is being replaced or void/canceled.**

Replacement/Void Claim Tips Continued

- **Only approved claims can be replaced or void/canceled. If the approved amount on any line of a claim states anything other than PEND or REJ, then the claim is considered approved.**

Beneficiary ID Changes

- New Beneficiaries ID will begin with #1
- Require 10-digit beneficiary IDs
- Transition period by county
- Medicaid will allow:
  - New 10-digit ID
  - Old 8-digit ID preceded with 00

Electronic vs. Paper Claims

Electronic Claims

- 997 Acknowledgment
- 1-2 Weeks to appear on an Remittance Advice
- No EOB needed
- List of approved Billing Agents located on the website under Electronic Billing

Paper Claims

- No Confirmation
- 6-9 months to appear on an Remittance Advice
- Need to attach EOB
- Processing Errors
- Manual keying errors

Edit 023 Rejection

- **The beneficiary <u>was not</u> eligible for Medicaid or Adult Benefit Waiver coverage on the date(s) of service**
- **RESOLUTION:**

  - Check Eligibility for DOS

Edit 025 (Rejection)

- **The beneficiary is enrolled in a Medicaid Health Plan. The provider should contact the Medicaid Health Plan for reimbursement.**
- **RESOLUTION:**
  - **Check Eligibility for DOS**
  - **Submit claim to Medicaid Health Plan**
  - **Medicaid Website under Health Care Coverage >> Medicaid**

Edit 462 (Rejection)

- **The beneficiary is only eligible for emergency services only (ESO) and elective services have been billed. The service must not be rebilled.**
- **RESOLUTION:**
  - **Beneficiary has limited coverage (ESO)**
    - **Check Scope Coverage Codes**
  - **Medicaid Manual**
    - **Beneficiary Eligibility, Section 2.1**
    - **Make sure claim is coded correctly**
    - **Electronic – Loop 2400 SV10**

Edit 492 (Rejection)

- **The beneficiary was not eligible for CSHCS, Medicaid, or ABW coverage on the DOS. The date(s) and beneficiary ID number should be verified. If appropriate, the claim should be corrected and rebilled. If the data is correct, the service must not be rebilled.**
- **RESOLUTION:**
  - **Check Eligibility for DOS**
  - **Beneficiary may have Medicaid Deductible**
  - **Medicaid Manual**

Edit 492 (Continued)

- Medicaid Deductible
- Beneficiary Eligibility, Section 4
- The Beneficiary is not eligible for Medicaid until they incur monthly medical expenses.
- Medicaid Deductible beneficiaries do NOT have Medicaid coverage when the deductible has not yet been met.
- Providers may bill the patient until the Medicaid eligibility is on the EVS file.

Edit 244/245 (Pend)

- The claim is being reviewed for possible Medicare coverage.
- RESOLUTION:
  - Make sure Medicare codes were used correctly.
  - Medicare cannot be coded as commercial insurance.
  - Medicaid Manual
- Coordination of Benefits, Section 2.6
- Website – Third Party Liability (TPL)

Edit 247(Pend)

- The beneficiary is age 65 or older and there is no indication that Medicare has made payment or applied the charge to the beneficiary's deductible.
- RESOLUTION:
  - If beneficiary is eligible for Medicare they must obtain it.
  - Make sure Medicare has been billed.
  - Need EOB if a paper claim
  - Make sure comments state No Part B or Part A only
- Medicaid Manual
  - Coordination of Benefits, Section 2.6
  - Website – Third Party Liability (TPL)

Edit 262 (Rejection) Other Insurance

- **The beneficiary data on the EVS system indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.**
- **RESOLUTION:**
  - **All Other Insurance listed on the EVS for the DOS MUST be reported on the claim.**
  - **Secondary/Tertiary Claims can be sent electronically without EOB attachments.**
  - **Medicaid Manual**
- **Billing and Reimbursement for Professionals, Section 6.2**

Edit 262 (Continued)

- To correct or update Other Insurance (OI) information on the TPL file, submit documentation to:
  - Fax (517) 346-9817
  - Email: TPL_Health@michigan.gov
- Make sure to include:
  - Subject “OI”.
  - DOS, Beneficiary ID, Contract/Policy number, Termination Date, etc.
- An EOB from the other carrier is the preferred documentation.

Edit 582 (Rejection)

- **An attempt was made to replace a Claim Reference Number (CRN) which has already been replaced. Only the last paid CRN can be replaced. The claim replacement should be rebilled using the last paid CRN.**
- **RESOLUTION:**
  - **Must use LAST PAID CRN.**
  - **Submit only to replace an APPROVED claim.**
  - **Medicaid Manual**
    - **Billing and Reimbursement for Professionals, Section 4**

Edit 093 (Rejection)

- **The procedure code or the combination of the modifier and procedure code is not covered on the date of service. The provider should verify the procedure code, modifier, and date of service. Provider should also verify the billing procedure with current manual material for possible changes. The claim should be corrected and rebilled.**
- **RESOLUTION:**
  - **The HCPCS is a valid HCPCS, but it is not covered by Medicaid on DOS.**
  - **Check the Procedure Code, Modifier and DOS.**
  - **Medicaid Website**
    - **Provider Specific Information**

Documentation EZ Link

- Electronic Claim Attachments
- Statewide Program
- No Fees for access
- Participation Requirements
  - Computer
  - Internet
  - Fax Machine (Optional)
- Trainings Posted Online

How to navigate the website

- **Web address: www.michigan.gov/mdch**